BEFORE THE
BOARD OF VOCATIONAL NURSING
AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Citation Against: TERESA SUZANNE GARDNER P.O. Box 2051 Redlands, CA 92373 Vocational Nurse License No. VN 95658 Respondent.	Case No. VN-2008-3221 OAH No. 2011050992

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Vocational Nursing and Psychiatric Technicians as the Final Decision in the above entitled matter.

This Decision shall become effective on October 25, 2012.

IT IS SO ORDERED this 25th day of September, 2012.

Todd D'Braunstein, PT
President

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In the Matter of the Citation Against:	
TERESA SUZANNE GARDNER,	Case No. VN-2008-3221
Vocational Nurse License No. VN 95658,	OAH No. 2011050992
Respondent.	

PROPOSED DECISION

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Bernardino, California on June 14, 2012.

Michael Brown, Deputy Attorney General, Office of the Attorney General, State of California, represented complainant Teresa Bello-Jones, J.D., M.S.N., R.N., Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians, Department of Consumer Affairs, State of California.

Janice Mendel, Attorney at Law, Messina, Lalafarian, Mendel & Ryan, represented respondent, Teresa Suzanne Gardner (respondent), who was present during the administrative proceeding.

Oral and documentary evidence was received and the matter was submitted on June 14, 2012.

FACTUAL FINDINGS

Jurisdictional Matters

1. On January 19, 2011, complainant Teresa Bello-Jones, J.D., M.S.N., R.N., in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians, Department Of Consumer Affairs, State of California (Board), signed the citation.

The citation alleged that respondent violated Business and Professions Code sections 2878, subdivision (a), unprofessional conduct; subdivision (a)(4), mistreating a patient, and 2518.6, subdivision (b)(1), failing to maintain current knowledge and skills for safe and competent practice. The citation alleged that on May 15, 2009, respondent withheld pain medication from a resident who called for it repeatedly and when finally given the medication, respondent yelled at her and treated her with disrespect. The citation sought a fine of $1,001.

Respondent was served with the citation and other required jurisdictional documents. She timely filed a notice of defense.

Respondent's Licensure

2. On June 2, 1980, the Board issued vocational nurse license number VN 95658 to respondent. That license expires on September 30, 2013, unless renewed, suspended or revoked.

There is no history of any discipline having been imposed against respondent's license.

Evidence Introduced at Hearing

3. On May 21, 2009, the convalescent facility where respondent worked reported to the California Department of Public Health (Department) that a resident claimed that respondent withheld her pain medication for four and one-half hours, telling the resident that she was busy with a new patient. The resident told her husband who called the respondent. The respondent then told the resident that she had been disrespected by the resident calling and telling her husband. The resident's roommate confirmed the events. This report resulted in an investigation by the Department.

4. Irma Chouehe, R.N., M.S.N., an investigator for the Department, reviewed records at the convalescent facility, interviewed the resident, her husband, the roommate, CNAs who worked at the facility, nursing supervisors and the administrator. Chouehe's report summarized the records she reviewed and the witnesses she interviewed. Chouehne never interviewed respondent, testifying that it was not "the policy" of the Department at that time. Chouehe testified about what the witnesses told her, but since none of those individuals testified in this hearing, Chouehe's testimony regarding what she was told was received as administrative hearsay pursuant to Government Code section 11513. Administrative hearsay can only be used to supplement or explain other evidence, but in and of itself, is insufficient to support a finding unless admissible on other grounds.

Chouehe testified that the resident told her she asked respondent for pain medication and rang her call light five times, beginning at approximately 4 PM. The resident stated that each time a CNA would enter her room and she would tell them she still needed her medication. At one point the resident was in tears and told her husband what was happening

when he called on the telephone. Her husband called respondent who then came into the resident's room, gave her the medication, yelled at her with an angry tone telling the resident, "How can you disrespect me that way, don't you realize that I had a new resident I had to do paperwork on?" The resident claimed that she told respondent that she did not know that and that the medication was four and one-half hours late. When interviewed, the resident told Chouehe that it had been seven hours since she last received her pain medication (Dilaudid) and that she had been requesting it for three hours.

On cross examination, Chouehe admitted that she never did any investigation to verify the times claimed by the resident, despite the fact she documented in her report the resident's claims of three, four and one-half and seven hours of waiting for medication.

A review of the records noted that the resident's pain medications were to be given on a "prn" (as needed) basis and that she had received a Lidoderm patch (pain patch) at 5 PM. Further, although Chouehe's report stated that the Controlled Drug Record for May 15, 2009, revealed that the following medications were signed out: one Dilaudid 4 mg at 10 AM, one Dilaudid four mg at 2 PM, and two Dilaudid 2 mg at 9 PM, a review of that document did not contain an entry for the 9 PM medication and complainant was unable to demonstrate how Chouehe derived that information for her report. Chouehe also admitted on cross examination that the resident had made several outlandish claims about respondent (cutting her hair, bleaching her clothes) which Chouehe could not substantiate. However, this never led her to doubt the resident's credibility which raised concerns about Chouehe's conclusions. Additionally, Chouehe was unable to answer many questions on cross examination repeatedly stating that she either did not recall or would need to review her notes, however, she never reviewed them while testifying and her notes were never introduced at this hearing.[1] As a whole, Chouehe's "investigation" and testimony were underwhelming at best.

5. Complainant called Brigitta Grimaldi as a witness who testified that she had been the administrator at the convalescent facility for approximately two weeks when this incident occurred. Grimaldi did not know if she had ever met respondent before the incident. Grimaldi split her time between this facility and another one. Grimaldi testified that the resident claimed she waited approximately three or four hours to receive her medication, but Grimaldi admitted she never checked the records to verify that assertion. Other than talk to the resident, Grimaldi did no further investigation other than to review the reports of others.

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[1] When asked by the administrative law judge why Chouehe's report noted that the resident "was originally admitted on 7/8/09 and readmitted on 3/31/09," which would make no sense, Chouehe acknowledged that the sequencing was out of order, but testified that it is "Department policy" to write it that way; she never considered that her dates were incorrect. However, later in the hearing, the evidence established (Respondent's exhibit 15) that the resident was originally admitted on 7/8/08, demonstrating that Chouehe's report was erroneous. The fact that Chouehe failed to consider that her report could be wrong further called into question her investigation because of her failure to check dates and times and corroborate witness assertions.

She never interviewed respondent. When the investigation was concluded, Grimaldi terminated respondent; she could not recall whether or not she had ever met respondent before the day she terminated her. Grimaldi's testimony was primarily received as administrative hearsay and established that her knowledge of the incident was based upon what others told her. Grimaldi also admitted that the facility had been the subject of numerous citations in the past and that several employees were terminated after Grimaldi was hired. That testimony established that Grimaldi was brought in to "clean house" and that respondent was simply "thrown out with the bathwater" during this phase. Respondent's termination, in and of itself, did not establish that she committed the violations asserted in the Citation.

6. Respondent called Susan DeGange as a witness. DeGange has been a registered nurse for 23 years. She was the director of nursing who recruited respondent from another facility after having worked with respondent. She testified about respondent's excellent nursing skills, honesty, integrity, work ethic, and ability to get the job done. A primary reason DeGange recruited respondent to work at the facility was because of difficulties with CNAs not performing their jobs at the facility and DeGange hired respondent to address that issue, which respondent did. DeGange's testimony established a reasonable explanation for why the CNAs may not have told respondent of the resident's request for her medication; i.e. anger at respondent for enforcing the facility rules. DeGange testified that the resident in this matter was a difficult patient, very demanding, who stayed in her room most of the day with her roommate. DeGange testified that one day the resident came up to her at the end of the day, was slurring her words, and asserting that respondent did not give her medications, that respondent had cut her hair, that respondent had bleached all of her clothes, and that she had damaged the arm cushion on her wheelchair. DeGange testified that these claims were unfounded as there was no evidence of her hair being cut or her clothes being bleached, and all the facility wheelchairs have scuff marks on the arm cushions. Given the resident's non lucid ramblings, DeGange dismissed her complaints.[2] DeGange testified that no one ever complained to her about respondent not providing pain medication, there were no complaints from staff or patients about respondent, and there were never before any complaints from the resident about respondent. In fact, respondent and DeGange had been working with the resident and her physician to help provide alternative pain treatment therapy to prevent the resident from sleeping throughout the day. DeGange disagreed with the facility's decision to terminate respondent but had no say in the matter.

7. Respondent has been licensed since 1980 and was continuously employed at various facilities until terminated from this facility in 2010. Respondent has always enjoyed a good reputation and was recruited to work at this facility. She was asked to ensure that CNAs performed their jobs and just prior to this incident informed several CNAs, including the CNAs who were interviewed by the Department, that she would have to write them up if

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[2] DeGange also explained that the complaints were made at the end of the day when DeGange was leaving work and right after DeGange had received word that her mother would soon die from her cancer so DeGange was taking a few days vacation from work to be at her mother's bedside. As such, she did not report the resident's complaints.

they did not comply. Respondent describe the excellent relationship she had with the resident. Respondent and DeGange had discussed alternative pain treatment therapy for the resident because the Dilaudid made her sleepy and respondent wanted to try other ways to relieve pain without that side effect. On the night in question, at approximately 5 PM, while tending to the resident's roommate, respondent also cared for the resident. Since it was too soon to give the resident another Dilaudid, respondent applied a Lidoderm patch and ensured the resident was comfortable. She was next in the resident's room at approximately 7 PM performing wound care on the resident's roommate and asked how the resident was doing. The resident had no complaints, was sitting on her bed eating a snack and watching TV. Respondent then left and was doing her rounds throughout the facility.

At approximately 9 PM while tending to some acute care patients, respondent was told she had a phone call. She went to the front desk to take the call and it was the resident's husband who began screaming at respondent that his wife was in pain and had been waiting hours for her medication. Respondent testified that she was "cold cocked" by the call, "I was dumbstruck." Respondent testified that she had never had any issues with the resident and had never met the husband so she was hurt by this encounter. Respondent testified she ran down the hallway to the resident's room to immediately medicate her. Respondent testified that there were two fans and the TVs on in the room which she did have to speak over, but denied that she yelled at the resident. Respondent testified that she specifically recalled what she said - "Arlene, in the future I'd appreciate you giving me the opportunity to resolve the problem before you call your spouse and tell him I am not taking care of you." Respondent then gave the resident her Dilaudid and that was when, for the first time, she learned from the resident that the resident had been repeatedly asking the CNAs to tell respondent that she wanted her medication. Respondent apologized to the resident. Respondent testified that she never had another bad encounter with the resident after she left the room. In fact, the following day respondent treated the resident and there were no issues. After that, respondent left on her pre-planned vacation and while there received a phone call from the facility about the investigation. Again, respondent was surprised by this development, she was even more shocked to learn she was terminated when she returned form her vacation.

Respondent credibly testified that the CNAs never informed her of the resident's medication request, had they done so, she would have given the resident her Dilaudid. Respondent denied ever being rude or disrespectful to the resident, but acknowledged that "it takes two" and if she had it to do over again she would have taken a moment after hanging up the phone to take a few deep breaths before going to the resident's room. Since being terminated, respondent has spent much time soul searching and reflecting on the incident, she has taken courses and read books regarding dealing with difficult patients and has thought long and hard about how her actions may have been perceived by the resident and how she needs to act differently in the future to prevent this type of interaction from occurring again. Respondent's testimony regarding this introspection was sincere, credible and heartfelt and she introduced certificates of completion and book summaries corroborating her testimony.

Evaluation

8. Although complainant argued that it had established the allegations in the citation and requested the citation be affirmed, the only evidence presented by complainant was administrative hearsay. Moreover, since complainant never interviewed respondent, she never learned respondent's side of the story. This was simply incomprehensible. Complainant did nothing more than rely on a report generated by the Department, a report shown to have many inconsistencies and which demonstrated that a complete investigation was never performed. There was no independent corroboration of the resident's allegations and much of the information contained in the report was wrong or incomplete as demonstrated on cross examination of the investigator. It was hard to understand not only why no investigation had been performed, but even more importantly, why, given that fact, a citation had been issued.

LEGAL CONCLUSIONS

Burden of Proof

1. The appropriate standard of proof in administrative citation proceedings is the preponderance of the evidence standard. (*Owen v. Sands* (2009) 176 Cal.App.4th 985, 992.)

Applicable Legal Matters

2. Protection of the public is the highest priority for the Board of Vocational Nursing and Psychiatric Technicians in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (Bus. & Prof. Code, § 2841.1.)

A licensed vocational nurse must safeguard patient/client health and safety by actions and must adhere to standards of the profession and incorporate ethical and behavioral standards of professional practice including maintaining professional boundaries with the patient/client. (Cal.Code.Regs, tit. 16, § 2518.6.) The Board may suspend or revoke a license for unprofessional conduct, which includes "the use of excessive force upon or the mistreatment or abuse of any patient.[3] (Bus. & Prof. Code § 2878, subd. (a)(4).) Under Business and Professions Code section 125.9, the Board has the authority to issue a citation to a licensee for violation of the Vocational Nursing Practice Act, and under California Code of Regulations, title 16, section 2523 the Board's executive officer may issue a citation in lieu of proceeding with more formal disciplinary action.

Administrative proceedings are not intended to punish the licensee, but rather to protect the public. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 785.) The main purpose of license discipline is protection of the public through the

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[3] By statute, "'excessive force' means force clearly in excess of that which would normally be applied in similar clinical circumstances."

prevention of future harm, and the improvement and rehabilitation of the licensee. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772.)

Relevant Statutory Provisions

3. Business and Professions Code section 2878, subdivision (a)(4), provides that the Board may suspend or revoke a licensee for unprofessional conduct, which includes, but is not limited to, the use of excessive force upon or the mistreatment or abuse of any patient.

Regulatory Authority

4. California Code of Regulations, title 16, 2518.6, subdivision (b)(1), provides that a licensee shall adhere to standards of the profession and shall incorporate ethical and behavioral standards of practice, maintaining current knowledge and skills for safe and competent practice.

Evaluation

5. Complainant's entire case was based upon administrative hearsay. No witness with any direct knowledge testified against respondent. Most disconcerting was the fact that at no time did respondent's employer, the Department, or the Board, interview respondent to obtain her side of the story. This was absolutely baffling given that this was clearly a he said/she said case; why no one would interview respondent was inexplicable.

In contrast, respondent and her witness provided direct evidence refuting the citation. Respondent and DeGange testified in an extremely credible manner, both were forthright, answered questions directly and came across as sincere, credible, thoughtful individuals. In fact, respondent's testimony demonstrated that she has reflected long and hard on the events of that evening, trying to understand how her actions played a role in the resident's perceptions, and using the experience as a learning tool for future patient interactions. Furthermore, the documents introduced in this case clearly supported respondent's version of events and refuted complainant's assertions. No direct or persuasive evidence supporting the citation was introduced. In fact, complainant's evidence clearly and convincingly demonstrated that this citation never should have been issued. It was disheartening that at the conclusion of this hearing the citation was not dismissed by complainant.

Cause Exists to Dismiss the Citation

6. Cause exists to dismiss the citation in its entirety. No evidence was introduced demonstrating that respondent violated Business and Professions Code section 2878, subdivisions (a), (a)(4), or California Code of Regulations, title 16, section 2518.6, subdivision (b)(1).

ORDER

The violations set forth in Citation Order No. CV-2008-3221 are dismissed.

DATED: June 14, 2012

MARY AGNES MATYSZEWSKI
Administrative Law Judge
Office of Administrative Hearings

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
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CITATION ORDER

Pursuant to Business and Professions Code Section 125.9, the Board of Vocational Nursing and Psychiatric Technicians (hereinafter referred to as the "Board") issues this class 'B' citation to:

Teresa S. Gardner, LVN
PO Box 2051
Redlands, CA 92373

Citation Number	Fine Assessed
CV-2008-3221	**$1,001.00**

Licensing History

Board records reflect that on **June 2, 1980** the Board issued license number **VN 95658** to **Teresa Suzanne Gardner;** said license will expire on **September 30, 2011** unless renewed.

Cause for Citation

Violation of **Section 2878 (a)** of the California Business and Professions Code, which reads as follows:

> The board may suspend or revoke a license issued under this chapter for any of the following:
> (a) Unprofessional conduct

Violation of **Section 2878 (a)(4)** of the California Business and Professions Code, which reads as follows:

> (4) The use of excessive force upon or the mistreatment or abuse of any patient.

Violation of **Section 2518.6 (b) (1)** of the California Code of Regulations, which reads as follows:

> (b) "A licensed vocational nurse shall adhere to standards of the profession and shall incorporate ethical and behavioral standards of practice…
> (1) Maintaining current knowledge and skills for safe and competent practice"

Explanation of Violation:

A Board investigation substantiated your unprofessional conduct while employed by Braswell's Yucaipa Valley Convalescent Hospital.

The Board's investigation concluded that on May 15, 2009, you withheld pain medication from a resident who had called for it repeatedly. When you finally gave her the medication, you yelled at her and treated her with disrespect.

Your actions demonstrate a failure to exercise the degree of professional judgment expected of a licensed vocational nurse. Such actions are inconsistent with standard practice and unacceptable for the licensed vocational nurse. Additionally, your actions evidence a lack of sensitivity to the rights and health care needs of clients. These failures diminish your therapeutic effectiveness as a provider of care and jeopardize the health, safety, and welfare of clients.

Fine and/or Order of Abatement

You are hereby ordered to pay an administrative penalty (fine) in the amount of **$1,001.00** within **thirty (30) calendar days after service of the citation.**

Payment of this administrative penalty should be made directly to the Board at 2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833. Payment will only be accepted in the form of a cashier's check or money order and must include the citation number. Please complete and submit the enclosed Payment of Fine – Waiver of Appeal Rights form with your payment.

Appeal Rights

You may appeal this citation or any portion thereof. Please use the enclosed Notice of Appeal form to request an Informal Citation Review Conference or a formal Administrative Hearing.

Your request for an Informal Citation Review Conference must be in writing and submitted to the Board within **fourteen (14) calendar days after service of the citation**.

Your request for a formal Administrative Hearing must also be in writing and submitted to the Board within **thirty (30) calendar days after service of the citation.**

Pursuant to Section 125.3 of the Business and Professions Code, the Board has authority to request the administrative law judge to direct you to pay reasonable costs for the investigation and/or enforcement of this citation. Please refer to the enclosed Statement of Rights for additional appeal information.

Failure to request an Informal Citation Review or Administrative Hearing within the time specified above will waive your right to contest this citation.

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer

1/19/2011
Date

ATTACHMENTS

- Payment of Fine – Waiver of Appeal Rights
- Notice of Appeal
- Statement of Rights

CJ